REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **James Healy-Pratt, HM Assistant Coroner for the area of East Sussex** in response to a Regulation 28 Report to Prevent Future Deaths following an inquest hearing into the death of Rodney Dixon on the 17th to the 19th of May 2021
1	**EAST SUSSEX COUNTY COUNCIL** I am Mark Stainton, Director of Adult Social Care, East Sussex County Council, St Anne's Crescent, Lewes, BN7 1UE
2	**CORONER'S MATTERS OF CONCERN** The MATTERS OF CONCERN were identified as follows: – Mental Health Act assessments are conducted in East Sussex deploying clinicians from both from both ESCC and SPFT (Sussex Partnership NHS Foundation Trust) and independent clinicians such as psychiatrists. The training around Mental Health Act assessments, patient risk management, and their Assessors is sub-optimal. Reasonable access to patient data by independent clinicians for MHA assessments need to be ensured prior to assessments.
3	**BACKGROUND** Rodney Dixon took his life on the 15th of July 2019 at his home in Eastbourne, during the course of a Mental Health Act assessment. The Assistant Coroner commenced an investigation into his death on the 23rd of July 2019 which concluded following a three day Inquest on the 19th of May 2021. The Assistant Coroner reached a narrative conclusion that the cause of death was Hanging and that Mr. Dixon took his own life, following a deterioration in his mental and physical health. The Assistant Coroner requested that East Sussex County Council review its' training in relation to Mental Health Acts assessments and "ensure there is clarity of understanding amongst all stakeholders that are involved in risk assessment". Written submissions were welcomed in relation to this issue, and ESCC submitted its' submissions on the 11th of June 2021. The Regulation 28 follows on from that.
4	**DETAILS OF ACTION UNDERTAKEN**. As a local authority, the Council is responsible for the recruitment, training, warranting and management of Approved Mental Health Practitioners (AMHPS). The Council has no input into the recruitment or training of Doctors and other medical staff who practise in this area. That is the responsibility of the Sussex Partnership Foundation Trust (SPFT) who have also been issued with a Regulation 28 notice.

	The Council has reviewed its' training and documentation in respect of AMHPs Since the conclusion of the Inquest, the following actions have been undertaken: (1) Leon Gooding (Head of Adult Social Care) hosted a meeting with all the Council's Approved Mental Health Practitioners (AMHPs) to discuss the issues arising from this case. During the meeting, It was agreed that the client in cases similar to that of Mr. Dixon should not be left unsupervised unless assessed to be of low risk. The Council's Mental Health Act referral and Risk Assessment Forms have been updated. They include a new section entitled "dynamic risk assessment". A copy of this new assessment is attached hereto. It is published on the Council's internal website. It says as follows "All individuals must be risk assessed with the aim to ensure their safety for the entirety of the assessment process, up to and including admission. **At no point throughout the assessment is the client to be left unsupervised unless assessed by the assessing team to be presenting with low current risk to self of others.** **It is the AMHP's responsibility to ensure the assessing team has access to the most recent risk assessment and relevant client clinical history."** (2) Yearly risk management training with Brighton University for existing AMHP's has been arranged. This is part of the annual training that AMHPs undergo anyway but it will now include specific training on risk management. (3) The AMHP warranting and re-warranting process has been updated. A dynamic risk assessment has to be completed and presented to the assessing team. It is now part of the process that AMHPs undergo as part of the warrant and re-warranting process.
5.	**DETAILS OF FURTHER ACTION PROPOSED** The actions the Council has undertaken above will be regularly reviewed and updated/amended if appropriate
6.	**SAFETY OF THOSE ASSESSED UNDER THE MENTAL HEALTH ACT** Every death by hanging is a tragic loss of life. The Council is committed to improving training for its AMHPs and in the way they conduct and implement Mental Health Act assessments The death of Rodney Dixon is a tragedy and the Council offers its' sincerest condolences to the family.
7.	**Signed** [redacted] [redacted]**, Director of Adult Social Care**